JOHN R. ASHCROFT
SECRETARY OF STATE
STATE OF MISSOURI

JAMES C. KIRKPATRICK
STATE INFORMATION CENTER
(573) 751-4936

STATE AUDITORS OFFICE
ELECTIONS DIVISION
(573) 751-2301

RECEIVED
MAR 12 2018

March 12, 2018

The Honorable Nicole Galloway
State Auditor
State Capitol Building
Jefferson City, MO 65101

RE: Petition approval request from Ted Melton regarding a proposed statutory amendment to Chapter 196 (2018-363)

Dear Auditor Galloway:

Enclosed please find an initiative petition sample sheet for a proposal to amend the Revised Statutes of Missouri filed by Ted Melton on March 12, 2018.

We are referring the enclosed petition sample sheet to you for the purposes of preparing a fiscal note and fiscal note summary as required by Section 116.332, RSMo. Section 116.175.2, RSMo requires the state auditor to forward the fiscal note and fiscal note summary to the attorney general within twenty days of receipt of the petition sample sheet.

Thank you for your immediate consideration of this request.

Sincerely,

John R. Ashcroft

cc: Hon. Joshua D. Hawley
Sheri Hoffman
Trish Vincent

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County

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It is a class A misdemeanor punishable notwithstanding the provisions of section 560.021, RSMo, to the contrary, for a term of imprisonment not to exceed one year in the county jail or a fine not to exceed ten thousand dollars or both, for anyone to sign any initiative petition with any name other than his or her own, or knowingly to sign his or her name more than once for the same measure for the same election, or to sign a petition when such person knows he or she is not a registered voter.

INITIATIVE PETITION

To the Honorable Jay Ashcroft, Secretary of State for the state of Missouri:

We, the undersigned, registered voters of the state of Missouri and _____ County, respectfully order that the following proposed amendment to the constitution shall be submitted to the voters of the state of Missouri, for their approval or rejection, at the general election to be held on the 6th day of November, 2020, and each for himself or herself says: I have personally signed this petition; I am a registered voter of the state of Missouri and _____ County (or city of St. Louis); my registered voting address and the name of the city, town or village in which I live are correctly written after my name.

[Official Ballot title]

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CIRCULATOR'S AFFIDAVIT

STATE OF MISSOURI, COUNTY OF

MO. STATE

_____

I, _____ being first duly sworn, say (print or type names of signers)

	NAME (Signature)	DATE SIGNED	REGISTERED VOTING ADDRESS (Number) (Street), (City, Town, or Village)	ZIP CODE	CONGR. DIST.	NAME (Printed or Typed)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

signed this page of the foregoing petition, and each of them signed his or her name thereto in my presence; I believe that each has stated his or her name, registered voting address and city, town or village correctly, and that each signer is a registered voter of the state of Missouri and _____ County.

FURTHERMORE, I HEREBY SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE BY ME ARE TRUE AND CORRECT AND THAT I

Notary Public (Seal)

Signature of Notary

My commission expires Address of Notary (Street, City, State & Zip Code)

NOTICE: You are advised that the proposed constitutional amendment may change, repeal, or modify by implication or may be construed by some persons to change, repeal or modify by implication, the following Articles and Sections of the Constitution of Missouri:

Title XII of the Missouri Revised Statutes: Chapter 196 sections 196.010, 196.050, 196.155, to be amended as follows.

Be it resolved by the people of the state of Missouri that the Title XII Public Health and Welfare, Chapter 196 be amended as follows:

A Bill amending prescribing protocols on dangerous drugs of abuse causing overdose death and addiction; sections amended include 196.050 196.175, 196.010,

Section 1. Section 196.050. To be amended as follows

1. Given the Opioid epidemic in the United States, the department of health and senior services shall prescribe or promulgate new regulations for drugs of abuse. These regulations may be more stringent than those listed under the authority of the Controlled Substances act of 1970 amendment due to the clear and present danger of overdose death.

2. All other products or commodities covered in sections 196.010 to 196.196.120 shall comply with the definitions and standards prescribed by the federal act.

Section 2. Section 195.195 to be amended as follows

3. Regulations, authority to promulgate, where vested. - The authority to promulgate regulations for the efficient enforcement of this chapter and chapter 579 is hereby vested in the director of the department of health and senior services subject to provisions of subsection 1 of section 195.030 and chapter 536. Given the Missouri preamble-
We the people of Missouri, with profound reverence for the Supreme Ruler of the Universe, and grateful for His goodness, do establish this constitution for the better government of the state. The Missouri constitution will promulgate its own definitions and regulations deliberating effective placement required for checking for the DSM5 disorders known as "Opioid Use Disorder" and "Substance Abuse Disorder," with a checklist to be enforced prior to prescribing a drug(s) listed in section 4 of this article.

Definitions
Emergency use for opioids- Opioids used under the care of a paramedic or doctor in an Emergency Room.

Section 3. Application requirements for common drugs of abuse and overdose potential

P.O.D.A.[3]
Preventing overdose death and abuse application

1. Applications screen for the DSM 5 disorder(s), *Substance Abuse Disorder, Opioid use disorder* before prescribing; opioid pain relievers, opium remedies, depressants, stimulants and partial opioid agonists. An increase in safety standard and responsibility level of prescriber, insurance provider and patient receiving care. Application are to be sent electronically to the state department of health and senior services every 7 days.

ii. Depressants

a. Alprazolam
b. Clonazepam
c. Diazepam
d. Lorazepam
e. Temazepam
f. Sodium oxybate

iii. Stimulants-

Short-acting:

a. Lisdexamfetamine
b. amphetamine salt
c. dextroamphetamine
d. dexmethylphenidate
e. methylphenidate
f. dextroamphetamine
g. methylphenidate
h. atomoxetine

Intermediate-acting:

i. amphetamine sulfate
j. methylphenidate
k. methylphenidate
l. methylphenidate
m. methylphenidate
n. methylphenidate

Long-acting:

o. dextroamphetamine
p. amphetamine
q. methylphenidate
r. methylphenidate
s. methylphenidate
t. methylphenidate

iv. Partial opioid agnostic or antagonist

g. Morphine naltrexone
h. Oxycodone naloxone
i. Buprenorphine
j. _____
k. _____
l. pentazocine hydrochloride
m. naloxone hydrochloride
n. buprenorphine buccal
o. buprenorphine transdermal
p. Sublocade
q. pentazocine/acetaminophen
r. Pentazocine/naloxone
s. Probuphine
t. Levo-alphacetylmethadol
u. Substances acting on opioid receptor function in the human or animal brain.

Section 5. Mental health check application screening for DSM5- *"Substance abuse disorder" and "Opioid Use disorder"*

a. The following applications are to be used by physicians, nurse practitioners and dentist conducting business in Missouri that are prescribing substances listed in section 3 of this document, *the substances of common overdose death and abuse list.*

Application for Prescribing Full Opioid agnostic drugs and remedies

For Doctors use only

1.) Has patient been to rehabilitation for any substance abuse?

_____
_____

2.) Is the patient nursing or pregnant?

_____
_____
—

3.) Is patient running out of medication before appointment?

_____
_____

4.) Is patient responsible for any children under the age of 21?

_____
_____

5.) Has the patient used heroine in the past or is presently intravenously injecting, snorting, smoking or ingesting any prescription medication, heroine, methamphetamine, bath salts, cocaine, buprenorphine or taking any illicit street drugs?

_____

8.) Is the patient injecting any drugs intravenously or through nasal passages?

9.) Is patient suicidal or had a suicide of a loved one in the past?

10.) Has patient been obtaining and ingesting any other full, partial or synthetic opioid medication from illegal or legal means?

11.) Opioids often taken in larger amounts or over a longer period of time than intended?

12.) There is a persistent desire or unsuccessful effort to cut down or control opioid use?

13.) Is a great deal of time spent in activities necessary to obtain the opioid, use the opioid or recover from its effect's?

14.) Craving or strong desire to use opioids?

15.) Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.

16.) Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids?

I certify that all the answers to the following questions are correct and I sign and certify with my signature under penalty of law that I have answered the evaluation correctly and that the person being prescribed Opioid drug therapy is not involved in illegal activities concerning drugs, sex trafficking, fraud, embezzlement, disturbing the peace, transfer of medication or be aiding in the manipulation of fetal embryo development and I do herby swear on my medical license that the application does not contain any false information and that I may be sued in a court of law under perjury of this acknowledgement that no harm from my prescribing will rest on the future of my patients health.

Application for Prescribing depressant drugs and remedies

For Doctors use only

1.) Has patient been to rehabilitation for any substance abuse?

2.) Is the patient nursing or pregnant?

3.) Is patient running out of medication before appointment?

4.) Is patient responsible for any children under the age of 21?

5.) Has the patient used heroine in the past or is presently intravenously injecting, snorting, smoking or ingesting any prescription medication, heroine, methamphetamine, bath salts, cocaine, buprenorphine or taking any illicit street drugs?

6.) Has the patient been prescribed or taking a partial opioid agonist, full opioid agonist, anti-anxiety, anti-depressant, stimulant or bipolar medication?

7.) Patient is not selling or abusing medication?

8.) Is the patient injecting any drugs intravenously or through nasal passages?

9.) Is patient suicidal or had a suicide of a loved one in the past?

10.) Has patient been obtaining and ingesting any other full, partial or synthetic opioid medication from illegal or legal means?

11.) Opioids often taken in larger amounts or over a longer period of time than intended?

14.) Craving or strong desire to use opioids?

15.) Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.

16.) Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids?

I certify that all the answers to the following questions are correct and I sign and certify with my signature under penalty of law that I have answered the evaluation correctly and that the person being prescribed Anti-anxiety medication is not involved in illegal activities concerning drugs, sex trafficking, fraud, embezzlement, disturbing the peace, transfer of medication or be aiding in the manipulation of fetal embryo development and I do herby swear on my medical license that the application does not contain any false information and that I may be sued in a court of law under perjury of this acknowledgement that no harm from my prescribing will rest on the future of my patients health.

Doctor's Signature

X

Date

X

Medical License number

DEA #

Application for Prescribing Stimulant drugs and remedies

For Doctors use only

1.) Has patient been to rehabilitation for any substance abuse?

2.) Is the patient nursing or pregnant?

6.) Has the patient been prescribed or taking a partial opioid agonist, full opioid agonist, anti-anxiety, anti-depressant, stimulant or bipolar medication?

7.) Patient is not selling or abusing medication?

8.) Is the patient injecting any drugs intravenously or through nasal passages?

9.) Is patient suicidal or had a suicide of a loved one in the past?

10.) Has patient been obtaining and ingesting any other full, partial or synthetic opioid medication from illegal or legal means?

These Questions Refer to the Past 12 Months

1. Have you used drugs other than those required for medical reasons? Yes No
2. Do you abuse more than one drug at a time? Yes No
3. Are you always able to stop using drugs when you want to? Yes No
4. Have you ever had blackouts or flashbacks as a result of drug use? Yes No
5. Do you ever feel bad or guilty about your drug use? Yes No
6. Does your spouse (or parents) ever complain about your involvement with drugs? Yes No
7. Have you neglected your family because of your use of drugs? Yes No
8. Have you engaged in illegal activities in order to obtain drugs? Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? Yes No

I certify that all the answers to the following questions are correct and I sign and certify with my signature under penalty of law that I have answered the evaluation correctly and that the person being prescribed amphetamine medication is not involved in illegal activities concerning drugs, sex trafficking, fraud, embezzlement, disturbing the peace, transfer of medication or be aiding in the manipulation of fetal embryo development and I do herby swear on my medical license that the application does not contain any false information and that I may be sued in a court of law under perjury of this acknowledgement that no harm from my prescribing will rest on the future of my patients health.

Doctor's Signature

X _____

Date

Application for Prescribing certain Partial Opioid agnostic/antagonist drugs and remedies

For Doctors use only

1.) Has patient been to rehabilitation for any substance abuse?

2.) Is the patient nursing or pregnant?

3.) Is patient running out of medication before appointment?

4.) Is patient responsible for any children under the age of 21?

5.) Has the patient used heroine in the past or is presently intravenously injecting, snorting, smoking or ingesting any prescription medication, heroine, methamphetamine, bath salts, cocaine, buprenorphine or taking any illicit street drugs?

6.) Has the patient been prescribed or taking a partial opioid agonist, full opioid agonist, anti-anxiety, anti-depressant, stimulant or bipolar medication?

7.) Patient is not selling or abusing medication?

8.) Is the patient injecting any drugs intravenously or through nasal passages?

9.) Is patient suicidal or had a suicide of a loved one in the past?

10.) Has patient been obtaining and ingesting any other full, partial or synthetic opioid medication from illegal or legal means?

11.) Opioids often taken in larger amounts or over a longer period of time than intended?

14.) Craving or strong desire to use opioids?

_____
_____
_____
_____

15.) Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.

_____
_____
_____
_____

16.) Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids?

_____
_____
_____
_____

I certify that all the answers to the following questions are correct and I sign and certify with my signature under penalty of law that I have answered the evaluation correctly and that the person being prescribed Partial opioid agnostic medication is not involved in illegal activities concerning drugs, sex trafficking, fraud, embezzlement, disturbing the peace, transfer of medication or be aiding in the manipulation of fetal embryo development and I do herby swear on my medical license that the application does not contain any false information and that I may be sued in a court of law under perjury of this acknowledgement that no harm from my prescribing will rest on the future of my patients health.

Doctor's Signature

X_____

Date

X_____

Medical License number

_____

DEA #

_____

Section 6. Submittal to Department of Health and Senior services

Every 7th day applications are to be submitted/mailed in paper format to the Department of Health and senior services 3418 Knipp Dr, Jefferson City, MO 65109.

Section 7. Section 196.155 to be amended and read as follows;

Penalties

Penalty. — Any person violating the provisions of section 196.150 shall be deemed guilty of a misdemeanor.

1. a.) Penalties for neglecting to preform proper urinary drug analysis and or complete the mental health check list or file applications with the Department of Health and Senior service pursuant to medications or substances contained in the common drugs of abuse and overdose death list found in section 3. will result in the following fine schedule will be payable to the TBD bureau.

b. After 24 hours late submission, a penalty of $1000.00 will be incurred.

c. The $1000.00-dollar penalty will be incurred daily to the prescriber of the medication listed in the common drugs of abuse and overdose death list until application has been received by the department of health and senior services.

d. Failure to preform proper urinary drug analysis, complete proper mental health check application or fraudulently signing application will result in